POC # 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445217	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE & REHABILITATION CENTER	1200 SPRUCE LANE ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure clinical justification for the use of an indwelling urinary catheter for one resident (#60) of three residents reviewed for the use of a urinary catheter of twenty-eight residents reviewed. The findings included: Resident #60 was admitted to the facility on April 2, 2014, with diagnoses including Pneumonia, Altered Mental Status, Seizure, Sepsis, Left Sided Hemiparesis, Atrial Fibrillation and Congestive Heart Failure. Medical record review of a Physician's order dated April 2, 2014, revealed "...Foley Catheter...foley care qsift (every shift) and PRN (as needed) Change foley Qmonth (every month) and PRN..." Interview with the Director of Nursing on September 25, 2014, at 8:45 a.m., in the	F 315	Pine Ridge Care & Rehab The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiency herein. The following plan constitutes the center's allegation of substantial compliance such that the alleged deficiencies cited have been corrected by the date(s) indicated. Resident #60 was discharged home 05/10/14 prior to State Survey 09/22/14-09/24/14. Corrective action was completed prior to discharge home which included medical justification for removal of foley catheter. All resident with a foley catheter would be affected if proper justification was not noted prior to insertion of foley catheter. All residents with foley catheters were assessed by DON/MDS coordinator and care plan reviewed and revised accordingly and justification was noted in chart for foley catheter use.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Street — TITLE: Administrator — (X6) DATE: 10-10-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 315	Continued From page 1 conference room confirmed the facility had failed to ensure clinical justification prior to the use of an indwelling urinary catheter.	F 315	Any resident admitted who comes with a foley catheter will be assessed by DON/ADON/Unit Mgr/Charge Nurses for proper diagnosis or justification & alert MD. MD will assess for proper justification & document accordingly & discontinuation of foley catheter will occur without proper justification or diagnosis. All admissions will be reviewed by DON/ADON on admission to facility for proper diagnosis or justification for foley catheter. Foley catheters will be assessed on quarterly & significant changes to MDS coordinators & any resident found to have foley catheter without proper diagnosis or justification will be brought to DON/ADON/Unit Mgr for physician to review. Foley catheter audit will be completed monthly for proper diagnosis or justification & findings will be presented by the DON to the QA/PI Committee for 3 months and/or until substantial compliance is achieved.	10/21/14
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure a safety alarm was functioning for one resident (#93), of three residents reviewed for falls of twenty-eight residents reviewed. The findings included: Resident #93 was re-admitted to the facility on July 12, 2013, with diagnoses including Anxiety Disorder, Dementia, Dysphagia, Muscle Weakness, and History of Stroke. Medical record review of the Annual Minimum Data Set (MDS) dated July 14, 2014, revealed the resident had severe cognitive impairment, required the assistance of two persons for transfers, and was wheelchair dependent for mobility. Review of the facility investigation dated	F 323		

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F 323	Continued From page 2 September 11, 2014, at 4:30 a.m., revealed "...Detailed Description: CNA's (Certified Nurse's Aides) observed resident on floor and notified... (nurse). Resident was sitting up on floor...Were there any interventions in place at the time of the fall? Yes...Pressure alarm to bed..." Telephone interview with CNA #1 on September 23, 2014, at 7:10 p.m., confirmed no alarm was sounding at the time the resident was found on the floor. Continued interview confirmed the pressure pad bed alarm was on the bed but was unplugged when checked after the fall. Telephone interview with Licenced Practical Nurse (LPN) #1 on September 23, 2014, at 9:25 p.m., confirmed the CNA's were doing rounds when the resident was found on the floor and no alarm was sounding.	F 323	F323 Resident #93 was assessed by DON and care plan was reviewed and revised accordingly for appropriate safety device to prevent accidents. Any resident with safety devices have the potential to be affected by deficient practice. Any resident with a safety device was assessed by DON/ADON/Charge Nurses for appropriate safety devices & care plan was reviewed & revised accordingly. Safety alarms will be added to EZ MAR System by DON/ADON/Charge Nurses/Unit Mgrs to document that they are 100% effective and/or will make necessary changes if not found to be 100% effective. Care plan will be reviewed & revised accordingly.	

Division of Health Care Facilities

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N 000	Initial Comments A licensure survey was completed on September 24, 2014, at Pine Ridge Care and Rehabilitation Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	Charge nurses will run omission reports each shift from EZ MAR System which details any missed documentation for that shift to ensure 100% of alarms were checked & in working order. DON/ADON/Unit Mgrs will audit compliance daily. The results of the audits will be presented by the DON to the QA/PI Committee for 3 months and/or until substantial compliance is achieved.	10/21/14

Division of Health Care Facilities
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